

Are Village Health, Sanitation, and Nutrition Committees Functional? Evidence from Chhattisgarh and Madhya Pradesh

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Abstract

Background: The Village Health, Sanitation, and Nutrition Committee (VHSNC) is a participatory effort aimed to strengthen the village-level agencies and to provide better health and sanitation services. However, there is a lack of evidence on the functionality of VHSNCs. **Objectives:** The present study aimed to explore the functionality of VHSNCs in the selected localities. **Materials and Methods:** The study was conducted in five districts of Chhattisgarh and Madhya Pradesh states. Using a multistage sampling method, a total of 508 VHSNCs were studied. The VHSNCs were considered as the unit of study. From each VHSNC, some key functionaries and its members were interviewed using a semi-structured interview schedule to understand the nature and effectiveness of its functioning. The researchers closely observed the meetings of VHSNCs and their records. Data were analyzed using descriptive statistical methods along with the impressions from the field notes. **Results:** The result of the study indicates that the functionality of the majority of the VHSNCs is not promising. Inadequate participation and improper implementation of key tasks are evident. **Conclusion:** The functionality of the VHSNC can be improved through the active involvement of Panchayati Raj Institutions and local communities.

Keywords: Community participation, health, sanitation, village health sanitation and nutrition committee

INTRODUCTION

Health, nutrition, and sanitation are the most crucial domains of social development. The same has been accepted in various frameworks and development agendas, including Sustainable Development Goals. Developing countries like India perform poorly in these domains. Kasthuri listed five crucial challenges of Indian health care such as lack of awareness, access, human resource, accountability, and poor affordability.^[1] In the domain of nutrition, also India performs poorly. It was shown that India is the home for one-third of the world's stunted children.^[2] Recent evidence also suggests that although there is slight betterment in the sanitation indicators, an issue like access to safe drinking water is remaining a challenge.^[3] In India, a glaring urban-rural divide is also evident in these crucial domains. The rural localities are ill-equipped with the accessibility to the health and sanitation facilities, while the urban poor is deprived due to affordability. Policy measures meant for addressing these issues are on operation in India.

Decentralization and participatory approaches are central to achieve desired health goals. Contextually, many programs in the health sector are devised in the participatory models in India. The Village Health, Sanitation, and Nutrition Committee (VHSNC) is such an effort aimed to strengthen the village-level agencies and to provide better health and sanitation services. VHSNC was devised by the National Rural Health Mission. It is considered as the grassroots level body to plan and implement health, nutrition, and sanitation targets at the village level. The sensitization of the local community, ensuring their active participation in planning and implementation, and equipping them to negotiate their health needs are the primary objectives of VHSNC.

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Although the VHSNCs are operational throughout the country, the functionality and effectiveness vary across regions and states. Majority of the available studies have shown the dismal state of implementation of VHSNCs while few studies suggest a promising trend to some extent. A study conducted in Jharkhand and Orissa shows that VHSNCs are not very successful in achieving the prescribed goals.^[4] The roles and responsibilities are largely unknown to the members of the VHSNCs, and the same is impacting its functioning.^[5] Another study shows poor awareness of members, and the tasks undertaken are not promising.^[6] Studies from three northeastern states reveal improper training imparted to the members and poor village-level planning.^[7,8]

However, some researches show positive indications of the committee. The evidence from Kerala shows positive aspects.^[9] A study from Maharashtra also indicates the same reflections.^[10] Another study showed that the villages with the VHSNC have better health-seeking behaviors.^[11] It is also evident that participation in the VHSNC also made women to better negotiate about the intra-community inequalities.^[12] Although many studies have been conducted on the themes surrounding VHSNC, there are gaps. The currently available literature largely focused on understanding the perspectives of VHSNC members. The functionality of VHSNCs as a grassroots intervention agency is not explored in detail yet. In this context, the present study aimed to explore the functionality of the VHSNCs in the selected localities of Chhattisgarh and Madhya Pradesh.

MATERIALS AND METHODS

Design, study locale, and samples

The present study employed a descriptive research design. The study was conducted in five districts of Chhattisgarh and Madhya Pradesh states. These states perform poorly in health, sanitation, nutrition, and other developmental indices. Five districts each from these two states were selected considering the existence of the highest number of VHSNCs. Subsequent to the selection of districts, a block was chosen from each district randomly. This was followed by the selection of villages randomly. The districts from Chhattisgarh included (number of villages in parenthesis) Bilaspur (46), Balod (50), Korba (26), Rajnandgaon (54), and Raipur (121). The districts from Madhya Pradesh included Hoshangabad (50), Chhindwara (46), Dewas (48), Sagar (56), and Narsinghpur (29). The VHSNCs studied from Chhattisgarh were 279, while 229 were from Madhya Pradesh, which is a total of 508. The VHSNCs were considered as the unit of study. From each VHSNC, a number of key functionaries, including its chairperson, accredited social health activist (ASHA), Anganwadi worker, and members, were interviewed.

Data collection and analysis

A semi-structured interview schedule was developed to collect crucial information about the functionality of the

VHSNCs. The focus was paid to explore the functionality and performance of the VHSNCs. The key operational aspects of the committees were explored from the perspectives of major functionaries. The field staff and researchers closely observed the meetings of VHSNCs and their records. Data were analyzed using a basic descriptive statistical method along with the descriptions of field notes.

Ethical concerns

The study strictly followed ethical guidelines for conducting studies with human subjects. Written informed consent was taken from participants of the study. The ethical approval for conducting the study was taken from the appropriate institutional body.

RESULTS

Formulation and composition of the Village Health, Sanitation, and Nutrition Committees

It was evident that around 90% of the VHSNCs followed the guidelines of the National Health Mission in its formulation. The ASHA of the particular village, in collaboration with the elected Panchayat members, has taken the initiatives for the formulation of most VHSNCs. However, the remaining 10% did not follow the procedures. The composition and related aspects of the VHSNCs are detailed in Table 1. The guidelines for the composition of the committees were not followed by most of the VHSNCs. The guidelines of VHSNCs suggested having at least 15 members. However, around 17% of the committees have <10 members. The inadequate participation of different stakeholders impacts the functionality of the VHSNCs to a great extent.

The VHSNC's guidelines mandate the participation of different stakeholders, including Panchayati Raj Institution (PRI) members, ASHA Anganwadi Workers, auxiliary nurse midwife, representatives from community-based organization/nongovernmental organization, service users, preexisting committees in the villages, and representation from SC/ST/minority communities. However, the indication from the study reveals that some of these stakeholders are underrepresented. The representations from SC/ST and minorities are also not promising. Further, 60% of the members are not trained as per the standards prescribed.

Meetings

VHSNCs are considered as the grassroots platform for the village-level planning, and the same is done through the regular meetings. The meeting and related aspects of the VHSNCs are detailed in Table 2. Around 39% of the VHSNCs were not provided prior information to its members about the meeting and agendas. The attendance of the VHSNC meetings is also a concern. Only 20% of the VHSNCs had above 90% attendance in the last year. It is alarming that >19% of the VHSNCs had attendance below 50% and around 14% had 51%–70% attendance. Improper and inadequate record-keeping is also prevalent. Thirty-seven percent of the VHSNCs had not kept proper records of the meetings.

Table 1: Composition of Village Health, Sanitation, and Nutrition Committees (n=508)

	Frequency		Total (n=508)
	Chhattisgarh (n=279)	Madhya Pradesh (n=229)	
Number of members			
15>	109	87	196 (38.5)
11-14	123	102	225 (44.2)
10<	47	40	87 (17.1)
Adequate participation of various stakeholders			
PRI (yes))	243	188	431 (84.8)
ASHA (yes)	279	229	508 (100)
AW (yes)	254	203	457 (89.9)
ANM (yes)	198	161	359 (70.6)
CBO/NGO (yes)	114	97	211 (41.5)
Service users (yes)	213	165	378 (74.4)
SC/ST/minority (yes)	207	154	361 (71.1)
Existing committees (yes)	55	41	96 (18.8)
Number of trained members			
None	21	32	53 (10.4)
1-2	73	68	141 (27.7)
3-4	90	75	165 (32.4)
5-10	73	41	114 (22.4)
11 above	22	13	35 (6.8)

Values in the parenthesis are percentage. PRI: Panchayati Raj institutions, ASHA: Accredited social health activist, AW: Anganwadi worker, ANM: Auxiliary nurse midwife, CBO/NGO: community based organization/non-governmental organization

Table 2: Meetings and related aspects (n=508)

	Frequency		Total
	Chhattisgarh	Madhya Pradesh	
Prior information about the meeting to members (yes)	204	106	310 (61.1)
Did a public notice publish on commonplace about the meeting? (yes)	126	182	308 (60.8)
The overall attendance of members in the last 1 year (%)			
91 above	54	49	103 (20.2)
71-90	121	103	224 (44)
51-70	51	20	71 (13.9)
Below 50	53	57	100 (19.6)
Record of the meetings maintained (yes)	184	150	318 (62.5)

Values in the parenthesis are percentage

The researchers closely observed the meetings of VHSNCs. It was observed that most of the meetings were not taken place in a serious mode, and rather, it became a formality. The core components, including health, sanitation, and nutrition, were not discussed rigorously. The minutes of previous meetings and measures taken were not discussed in most of the meetings. Most of the meetings lasted <30–40 min. Getting the signature of absent members afterward also is found to be a prevalent practice. Most of the meetings were organized without the proper agenda and without taking minutes of the meeting.

Monitoring and management

The monitoring and management aspects of the VHSNCs are also not found very promising, though some of them are doing better. Sixteen percent of the VHSNCs do not have a functional bank account, which is mandatory for the functionality of the committee as per the guidelines [Table 3]. The majority of the

VHSNCs have utilized the untied fund. However, 21% of the VHSNCs were not utilized the same in the last year. Thirty-five percent of the VHSNCs have not maintained a village health register as per the guidelines.

Activities and major outcomes

The VHSNCs are formed with a broad purpose of engaging with the various needs of the local community. Apart from the three major domains (health, nutrition, and sanitation), VHSNCs are supposed to involve in the functioning of allied areas. However, the broad spectrums of the functionality of the VHSNCs are always not followed. The reflections from the present study also underline that most of the VHSNCs are failed to make promising interventions in the communities. It was evident that the most common component of the program undertaken by the VHSNCs is health promotion activities. The activities and outcomes of the functioning of VHSNCs

are detailed in Table 4. Around 86% of the VHSNCs have organized various health promotion activities in the villages. However, for most of the VHSNCs, such programs are limited only to the cleaning and sanitation drive. Some of the VHSNCs have engaged in awareness and sensitization programs on various diseases/health issues throughout the year.

As VHSNCs have very broad objectives, it is supposed to involve as a facilitating agent for various services in the villages. In the present study, around 29% of the VHSNCs have not taken such a role of facilitating agent. Ideally, VHSNCs are supposed to monitor and facilitate the provisions and programs such as public distribution system, mid-day meal, Anganwadi, and Mahatma Gandhi National Rural Employment Guarantee Scheme. However, most of the VHSNCs are involved only with the Anganwadi services. Although VHSNC supposes to monitor the community health centers and primary health centers, 69% of the VHSNCs were not involved in such roles. The VHSNCs involved also revealed that they play very minimal roles in such efforts.

The village health plan (VHP) is considered as one of the crucial documents to be prepared by the VHSNCs and implement programs accordingly. It was found that 85% of the VHSNCs have prepared VHP for the last year. However, the implementations of the programs were not followed as per the VHP. Most of the VHSNCs also have followed the same VHP for many years continuously. Special focus on the issues and concerns of marginalized communities was not taken by 36% of the VHSNCs.

The roles of VHSNCs also include proactive engagement for making the system better and accessible for the people. The committee is supposed to intervene with the government authorities and departments for better health, nutrition, and sanitation outcomes. However, it was evident that >92% of the

VHSNCs have not made any formal complaints to the appropriate authorities in the past for better services in the village.

DISCUSSION

In the present study, an attempt was made to explore the functionality of the VHSNCs operating in the states of Chhattisgarh and Madhya Pradesh. The study could locate the ground realities of the functioning and the outcomes of the VHSNCs. The study indicates that most of the VHSNCs have followed the guidelines for the formulation. However, the composition of the VHSNCs is not in accordance with the guidelines. The participation of different stakeholders, especially people from disadvantaged communities, is found to be poor. A study conducted in one of the northwestern states also found similar indications.^[13]

Although the organization of meetings is one of the important tasks of the VHSNCs, most of the studied committees did not operationalize it seriously. Prior and appropriate information was not provided to the members about the meeting and its agenda. A considerable proportion of the VHSNCs reportedly had attendance below 50% in most of the meetings. The study result is similar to a study conducted in Punjab, which shows that most of the monthly meetings did not happen, and the attendance of members was just half.^[14] Similarly, another study from Assam also showed that around only 17% of the VHSNCs had conducted regular monthly meetings in the assessed year.^[15] The present study evidence that the meetings of VHSNCs were not done in a serious mode.

The management and monitoring of VHSNCs are not found very promising. More than 85% of the VHSNCs have a bank account, and around 80% of them have utilized the fund in the last year. The important records supposed to be kept by the VHSNCs have not been followed accordingly

Table 3: Management and monitoring (n=508)

	Frequency		Total
	Chhattisgarh	Madhya Pradesh	
Functional bank account (yes)	235	192	427 (84)
Proper/timely utilization of untied funds (yes)	212	187	399 (78.5)
Maintenance of village health register (yes)	177	155	332 (65.3)

Values in the parenthesis are percentage

Table 4: Activities and outcomes (n=508)

Activities and outcomes	Frequency		Total
	Chhattisgarh	Madhya Pradesh	
Health promotion activities (yes)	246	191	437 (86)
Facilitation of service delivery (yes)	217	145	362 (71.2)
Monitoring of health facilities (CHC and PHC) (yes)	84	72	156 (30.7)
Annual village health plan (yes)	234	198//	432 (85)
Special focus on the needs of marginalized communities (yes)	207	117	324 (63.7)
Formal complaints to relevant government authorities? (yes)	31	12	43 (8.4)

Values in the parenthesis are percentage. CHC: Community health centre, PHC: Primary health centre

by most committees. The untied fund has been used mainly for the sanitation drives and awareness campaigns. Contrary to this result, a study conducted in Punjab showed that the majority of the funds are utilized for administrative tasks.^[16] The fund utilization in the VHSNCs needs improvement as a considerable proportion of funds could be utilized for innovative tasks.

One of the flaws in the implementation of VHSNCs evident from the present study was the failure to make promising interventions in the communities on different components of the program. Most of the VHSNCs have focused on the health promotion components, and the other domains were not given priority. The health promotion activities were limited only to sensitization programs, and monitoring was limited to Anganwadis. The proactive engagement of VHSNCs with the government and village machinery was found missing. Similar instances were evident in the previous studies as well.^[13,14] It is essential to devise appropriate intervention programs to revive the functionality of the VHSNCs. Various community-based programs were found effective in bringing the VHSNC's functionality better.^[17-19] Although the functionality of VHSNCs in Chhattisgarh and Madhya Pradesh does not differ much, some components were found better in Chhattisgarh, especially the participation of disadvantaged sections. The functionality of the VHSNCs is determined by various sociocultural and political factors and needs further investigation.

CONCLUSION

The functionality of VHSNCs was explored in the present study. Although VHSNCs are operational in almost all villages, its functionality is not as per the guidelines. The inclusiveness in the composition of VHSNCs is also not promising. Poor organization and lack of participation are also evident in the meetings of VHSNCs. The majority of the studied VHSNCs have focused on the health promotion domain, and other aspects did not get attention. The utilization of untied funds is promising, but its innovative use is lacking. The VHP is also not taken seriously by most of the committees. Further studies are required to understand the determinants of successful implementation of the committees. Active involvement of PRIs will improve the functionality of the VHSNCs. There should be measures for the timely monitoring of VHSNCs. Community-based interventions should be commissioned to improve the functionality of the VHSNCs.

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Conflicts of interest

There are no conflicts of interest.

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